July 1, 2016

Re: **Motion Picture Industry Health Plan**
Notice of Special Window Period for Filing Claims

Dear Participant:

The Motion Picture Industry (MPI) Health Plan will accept as timely, claims (including otherwise untimely claims) filed by September 15, 2016 that meet the following conditions:

1. If you were allergic to a specific dye in a generic drug and have submitted a report of the adverse event to the FDA's Safety Information and Adverse Event Reporting Program on Medwatch, the Plan will approve the brand-name medications. If you previously had a claim denied by the Plan for coverage of a brand name drug and you had such an allergy as described above, you may re-submit the claim to the Plan during this special window period.

2. The Plan's Administrative Office does not accept emailed claim forms, and in the future, will not authorize any exceptions to this rule. If you previously emailed a claim form to the Plan's Administrative Office and it was not processed by the Plan, you may re-submit the claim during this Special Window Period.

3. If at any time after January 1, 2011, your eligibility through the Plan was terminated retroactively for reasons other than fraud, intentional misrepresentation or your failure to pay premiums, you may submit or re-submit claims for services rendered during that retroactive period and during the 30 day period after you were notified of the termination of your coverage.

Special Window Period claims should be submitted by mail (not email) to:
Benefits/Appeals Committee
Motion Picture Industry Health Plan
P.O. Box 1999
Studio City, CA 91614-0999

Sincerely,

Board of Directors
Motion Picture Industry Health Plan

For additional information or questions regarding your benefits, email MPI's Participant Services Center at service@mpiphp.org, or call toll-free at (855) ASK-4MPI (855-275-4674), from 8 a.m. to 5 p.m. PST, Monday through Friday.

July 1, 2016

To: Participants, Motion Picture Industry Health Plan

From: Board of Directors, Motion Picture Industry Health Plan

Re: **Clarification of the Motion Picture Industry Health Plan's** ***Summary Plan Description for Active Participants – October 2013*** **and** ***Summary Plan Description for Retired Participants – December 2015***

This Notice is intended to clarify important information included in the Motion Picture Industry (MPI) Health Plan's *Summary Plan Description* that was previously provided to you. Please note the section of this Notice that is applicable to you, as this Notice provides updates for both Active Participants and Retired Participants.

Keep this Notice with your *Summary Plan Description* and refer to it for future questions you may have regarding your health care coverage through MPI.

Please note the following with respect to your coverage through the MPI Health Plan:

SUMMARY PLAN DESCRIPTION FOR ACTIVE PARTICIPANTS – PAGE 60

Physical Examinations

Newborn Through Age 17
The Plan covers well child care visits for eligible Dependent children who are newborn through age 4 according to pediatrician recommendations, and covers physical examinations once per calendar year for eligible Dependent children ages 5 through 17.

Age 18 and Older
The Plan covers Comprehensive Physical Exams (CPE) for Participants and their eligible Dependents once per calendar year.

Service Location Requirements:

Newborn Through Age 12
Participants may use a physician of their choice for well child visits/physical exams for their eligible Dependents who are newborn through age 12. Please note that it is preferred that an Anthem Blue Cross network physician is used.

Age 13 Through Age 17
Participants may use UCLAHealth/MPTF Health Centers or the physician of their choice (Anthem Blue Cross network physicians are preferred) for annual physical exams for their eligible Dependents ages 13 through 17. Please note the UCLAHealth/MPTF Health Centers only see patients who are age 13 or older for both wellness and general primary care.

Age 18 and Older
If you are age 18 and older and the last home address you have provided to the Plan on or before the date of your CPE is in Los Angeles County, you must use the UCLAHealth/MPTF Health Centers for the CPE covered by this Plan. *See "The Wellness Program," page 121*. If the last home address you have provided to the Plan on or before the date of your CPE is outside of Los Angeles County, you may go to the physician of your choice.

SUMMARY PLAN DESCRIPTION FOR ACTIVE PARTICIPANTS – PAGE 121

Comprehensive Physical Exams (MPIHP/Anthem Blue Cross Only)

If the last home address a Participant or eligible Dependent age 18 and older has provided to the Plan is in Los Angeles County, the Participant or Dependent must use one of the UCLAHealth/MPTF Health Centers listed on page 70 to obtain this benefit. Simply call the Health Center of your choice and make an appointment. UCLAHealth/MPTF Primary Care Physicians are experts in preventive care and will discuss general health issues and ways you can lead a healthier life. *Please see page 60 for information applicable to non-HMO Participants living outside Los Angeles County.*

SUMMARY PLAN DESCRIPTION FOR RETIRED PARTICIPANTS – PAGE 46

Physical Examinations

Newborn Through Age 17
The Plan covers well child care visits for eligible Dependent children who are newborn through age 4 according to pediatrician recommendations, and covers physical examinations once per calendar year for eligible Dependent children ages 5 through 17.

Age 18 and Older
The Plan covers Comprehensive Physical Exams (CPE) for Participants and their eligible Dependents once per calendar year.

Service Location Requirements:

Newborn Through Age 12
Participants may use a physician of their choice for well child visits/physical exams for their eligible Dependents who are newborn through age 12. Please note that it is preferred that an Anthem Blue Cross network physician is used.

Age 13 Through Age 17
Participants may use UCLAHealth/MPTF Health Centers or the physician of their choice (Anthem Blue Cross network physicians are preferred) for annual physical exams for their eligible Dependents ages 13 through 17. Please note the UCLAHealth/MPTF Health Centers only see patients who are age 13 or older for both wellness and general primary care.

Age 18 and Older
If you are age 18 and older and the last home address you have provided to the Plan on or before the date of your CPE is in Los Angeles County, you must use the UCLAHealth/MPTF Health Centers for the CPE covered by this Plan. *See "The Wellness Program," page 105*. If the last home address you have provided to the Plan on or before the date of your CPE is outside of Los Angeles County, you may go to the physician of your choice.

SUMMARY PLAN DESCRIPTION FOR RETIRED PARTICIPANTS – PAGE 105

Comprehensive Physical Exams (MPIHP/Anthem Blue Cross Only)

If the last home address a Participant or eligible Dependent age 18 and older has provided to the Plan is in Los Angeles County, the Participant or Dependent must use one of the UCLAHealth/MPTF Health Centers listed on page 55 to obtain this benefit. Simply call the Health Center of your choice and make an appointment. UCLAHealth/MPTF Primary Care Physicians are experts in preventive care and will discuss general health issues and ways you can lead a healthier life. *Please see page 46 for information applicable to non-HMO Participants living outside Los Angeles County.*

July 1, 2016

To:	Participants, Motion Picture Industry Health Plan
From:	Board of Directors, Motion Picture Industry Health Plan
Re:	**Changes to the Motion Picture Industry Health Plan**

This Notice contains important information about changes to your Plan benefits. These changes constitute material modifications to the benefits set forth in the Motion Picture Industry Health Plan's *Summary Plan Description for Active Participants (October 2013)*. As a legal Summary of Material Modifications, please keep it with your Summary Plan Description (SPD) for future reference.

The following changes are being made to the Plan:

SUMMARY PLAN DESCRIPTION - PAGE 46

Allowable Amount
The allowable amount is the maximum amount that the Plan will consider for payment for a covered service and the charged amount is the amount billed by the provider. For in-network providers, the allowable amount is the contracted rate between Anthem Blue Cross or the BlueCard Program and the in-network providers. For out-of-network providers, the allowable amount is determined by Anthem Blue Cross for services provided in California or by the local BlueCard network for services provided outside of California.

For all claims, the allowable amount is never more than the billed charge for the service. The allowable amount varies by service/procedure, location and provider type and is subject to change. **Using an out-of-network provider may subject the Participant to balance billing. The Plan will pay claims based on the allowable amount in effect at the time of service.**

In California (Anthem Blue Cross)
The out-of-network allowable amount is based on an analysis of usual, customary, and reasonable (UCR) rates for a specific geographic area based on pricing rates in a FAIR Health data base. The allowable amount is set at the 70th percentile, which means that the UCR rates are greater than or equal to the charges billed for that service/procedure by 70% of the providers in the geographic area.

Out of California (BlueCard Program)
Anthem Blue Cross has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of the Anthem Blue Cross service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program, and may include negotiated National Account arrangements available between Anthem Blue Cross and other Blue Cross and Blue Shield licensees.

To determine coverage, refer to chart on page 47 - "Coverage Rates by Provider Categories."

SUMMARY PLAN DESCRIPTION - PAGE 47

Schedule of Allowable Amount
The allowable amount is the maximum amount the Plan approves for a procedure or examination. Allowable amounts vary by procedure type and number, physician, network affiliation and geographic area. Reimbursement to the physician will be a percentage of the allowable amount.

Surgical services
1. In-network California: the allowable amount is determined by individual contracts between the surgeon and Anthem Blue Cross. With a TIHN referral, the surgeon is paid at 100% of the allowable contracted rate. Without a TIHN referral, the surgeon is paid at 90% of the allowable contracted and the Participant is responsible for 10%.
2. Out-of-network California: The allowable amount is determined by the Usual, Customary and Reasonable (UCR) rate as determined by Anthem Blue Cross. The surgeon is paid at 50% of the allowable or UCR rate. If more than one procedure is done, the primary procedure is paid at 50% of the allowable amount, and additional procedures are paid at 25% of the allowable amount. The Participant can be balance billed up to the charged amount.
3. In-network out of California: The allowable amount is determined by the Blue Card Program using a fee schedule for in-network surgeons that can vary state to state and by contracted provider. The surgeon is paid at 90% of this fee schedule and the Participant is responsible for 10%.
4. Out-of-network out of California: The allowable amount is determined by the BlueCard Program for out of network surgeons that can vary state to state. The surgeon is paid at 50% of the allowable amount. If more than one procedure is done, subsequent procedures are paid at 25% of the allowable amount. The Participant can be balance billed up to the charged amount.

To determine coverage, refer to chart on page 47 - "Coverage Rates by Provider Categories"

SUMMARY PLAN DESCRIPTION - PAGE 60

HMO Enrolled Participants
Participants who have selected one of the Health Maintenance Organizations (HMOs) offered by the Plan must use the HMO for mental health and chemical dependency benefits.

Further Information
Please refer to the OptumHealth Schedule of Benefits for a complete description of your behavioral health benefits. To request a copy, please call OptumHealth at 888.661.9141. To review or search an online list of OptumHealth network providers, go to www.liveandworkwell.com, use the access code MPIPHP, or call toll-free 888.661.9141.

SUMMARY PLAN DESCRIPTION - PAGE 74

This overview of benefits is intended to be a general summary of your behavioral health benefits. Please refer to the OptumHealth Schedule of Benefits for a complete benefit plan description. To request a Schedule of Benefits, contact the OHBS Customer Service Department.

The following addition is being made to the Plan:

SUMMARY PLAN DESCRIPTION - PAGE 115

If you were allergic to a specific dye in a generic drug and have submitted a report of the adverse event to the FDA's Safety Information and Adverse Event Reporting Program on Medwatch, the Plan will approve the brand-name medications. If you previously had a claim denied for coverage of a brand name drug and you had such an allergy described above, you may re-submit the claim during this special window period.